2014

Louisiana Ebola Response Plan

Governor's Office of Homeland Security and Emergency Preparedness

Contents

Subject

Ebola is a virus that has worldwide consequences. Confirmed or suspected cases of Ebola present special requirements for disease surveillance, public communications, allocation of medical resources, and expansion of human services.

Background

The current Ebola outbreak in West Africa has increased the possibility of patients with Ebola traveling from the affected countries to the United States. 1 The likelihood of contracting Ebola is extremely low unless a person has direct unprotected contact with the body fluids of a person (like urine, saliva, feces, vomit, sweat, and semen) or direct handling of bats, rodents, or nonhuman primates from areas with Ebola outbreaks. 2 Initial signs and symptoms of Ebola include sudden fever, chills, and muscle aches, with diarrhea, nausea, vomiting, and abdominal pain occurring after about 5 days. Other symptoms such as chest pain, shortness of breath, headache, or confusion, may also develop. Symptoms may become increasingly severe and may include jaundice (yellow skin), severe weight loss, mental confusion, bleeding inside and outside the body, shock, and multi-organ failure.

3 Ebola is an often-fatal disease and care is needed when coming in direct contact with a recent traveler from a country with an Ebola outbreak that has symptoms of Ebola. The initial signs and symptoms of Ebola are similar to many other more common diseases found in West Africa (such as malaria and typhoid). Ebola should be considered in anyone with fever who has traveled to, or lived in, an area where Ebola is present. The incubation period for Ebola, from exposure to when signs or symptoms appear, ranges from 2 to 21 days (most commonly 8-10 days). Any Ebola patient with signs or symptoms should be considered infectious. Ebola patients without symptoms are not contagious. The prevention of Ebola includes actions to avoid exposure to blood or body fluids of infected patients through contact with skin, mucous membranes of the eyes, nose, or mouth, or injuries with contaminated needles or other sharp objects.

Emergency medical services (EMS) personnel, along with other emergency services staff, have a vital role in responding to requests for help, triaging patients, and providing emergency treatment to patients. Unlike patient care in the controlled environment of a hospital or other fixed medical facility, pre-hospital care is typically provided in an uncontrolled setting. This setting is often confined to a very small space and frequently requires rapid decision-making and life-saving interventions based on limited information. EMS personnel are frequently unable to determine the patient history before having to administer emergency care.

Coordination among 9-1-1 Public Safety Answering Points (PSAPs), the EMS system, healthcare facilities, and the public health system is important when responding to cases with suspected Ebola. Each 9-1-1 and EMS system should include an EMS medical director to provide appropriate medical supervision.

Purpose

The intent of the Ebola Response Annex to the Louisiana State Emergency Operations Plan (EOP) is to provide general guidance to parish, State, and Federal Governments and all stakeholders in the preparation of plans specific to an Ebola response. The specific purposes of this document are as follows:

1. Protect life and property
2. Minimize exposure particularly in the following sectors:
    a. Schools - particularly those of higher learning as students and faculty may be conducting research in West Africa
    b. Faith based organizations - as they have missionary/humanitarian efforts in affected countries
    c. Ports, Airports
    d. Oil and Gas Industry
    e. First Responders
3. Conduct active medical and public health vigilance so as to identify and isolate symptomatic cases.
4. Identify consequence management steps for confirmed case(s) and their contacts.
    a. Pathway 1: symptomatic patients that enter healthcare system
    b. Pathway 2: house-hold contacts that may be confined in their home.
5. Support rapid & effective response
6. Collect and disseminate accurate incident and public information to improve decision making, dispel rumors, and promote public awareness.

Assumptions

1. Local governments have the primary responsibility to provide initial emergency response and emergency management services within their jurisdictions.
2. State government may provide and/or augment emergency response services that exceed the capabilities of local governments as per the State EOP.
3. In the response to a confirmed case of Ebola in Louisiana, the Governor will activate the State's Emergency Response Plan under the command of the Director of GOHSEP.
4. State Emergency Operations Center will be activated to appropriate level.
5. Unified Command Group (UCG) will assemble immediately to set response actions in motion.
6. Joint Information Center (JIC) will be activated
    - Develop Press Releases
    - Develop Canned Responses that can be used by all agencies PIOs
    - Aggressive factual information sharing to the public/news media
7. State response actions will begin.

State agencies will continue to have ongoing meetings to refine response plans for various scenarios.

8. Parish conference calls will be conducted immediately with affected parishes to obtain and provide information and guidance. GOHSEP would maintain continual contact with affected parish officials and State and local response agencies ensuring an immediate and coordinated response.
9. Support request for local and State agencies would be facilitated immediately via Web EOC.
10. Public Health Emergency Declaration will be issued.

Concept of Operations

Key Stakeholders

- Parish Offices of Homeland Security and Emergency Preparedness
- Parish 911/PSAP
- Parish EMS
- Local law enforcement agencies
- Parish Coroner's Offices
- Local Funeral Homes
- Parish Health Units
- Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP)
- Department of Health and Hospitals
- Louisiana State Police (LSP)
- State and Federal (HHS/CDC) ESF 8 partners
- DCFS

Phase 1: Assessment and Confirmation of Ebola Cases

- Suspect Cases are reported to DHH / Office of Public Health/Infectious Disease Epidemiology (ID Epi) Section: 1-800-256-2748

- ID Epi will determine if suspected case rises to probable using the conditions below.

    1. ID Epi, in consultation with CDC, determines whether the suspected case requires confirmatory testing at a CDC-certified LRN Lab. IF ID Epi, in consultation with CDC, believes that confirmatory testing is needed, then the individual is immediately treated as a patient under investigation (PUI). Patient would then be placed in isolation at a hospital if not already there. If there is a probable case we would not delay the start of our investigation while labs are pending.
    2. Hospital sends the sample to CDC or other approved LRN lab chosen by the state; whichever allows for the fastest turnaround time.
    3. Confirmatory test results can take between 48-72 hours. The individual would be considered a patient under investigation (PUI) and isolated immediately if they are exhibiting symptoms and have a travel or exposure history.
    4. Lab results are shared with the ID Epi and State Health Officer.

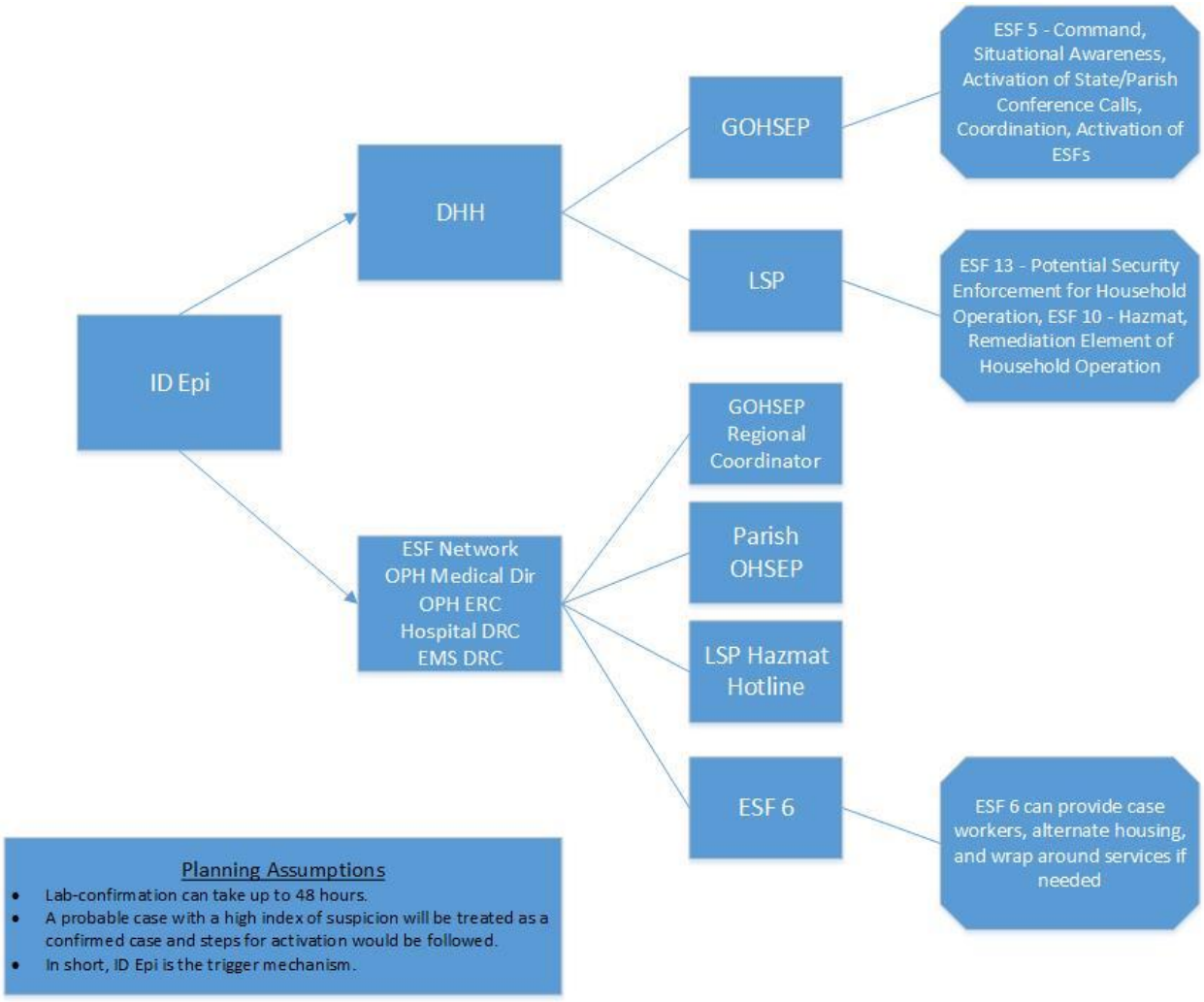
5. ID Epi shares information with patient and hospital.
6. Notification procedures are shown later in this document.

Phase 2: Notification Process

- For a suspect case of Ebola:
    - Notification procedures are:
        - "Unfolding events" where several/varied inquiries are being made about a suspect case
        - Potential cases as flagged/identified by ID Epi
        - DHH notifies GOHSEP Emergency Ops Center by phone and email (gohsep-idepi@listserv.doa.la.gov)
            - Email includes GOHSEP, LSP and DHH command staffs

- For a Probable (PUI) and LAB-CONFIRMED case of Ebola (See Figure 1):
    - Notification procedures are:
        - The CDC lab director will call the State Health Officer and State Epidemiologist, and alert the CDC Emergency Operations Center/Director of the CDC.
        - The State Health Officer / State Epidemiologist will immediately alert the GOHSEP Emergency Ops Center by phone and email (gohsep-idepi@listserv.doa.la.gov)
            - Email includes GOHSEP, LSP and DHH command staffs
        - The State Health Officer / State Epidemiologist will immediately alert DHH Emergency Operations Center (DHH EOC).
        - DHH notifies LSP Hazmat Hotline (1-877-925-6595 or 225-925-6595)
        - GOHSEP will immediately inform the Governor, and all ESF partners, and parish OHSEP directors.
        - DHH will immediately activate the DHH EOC, and alert all Subject Matter Experts and our Public Health Regions.
        - A Joint Information Center will be activated through the GOHSEP EOC to alert, respond, and educate the public about the event.
        - Healthcare and emergency response partners will be alerted through the Health Alert Network.

Figure 1: Notification Process: Lab-Confirmed Case



Phase 3: Consequence Management Steps

Confirmed case is placed in hospital setting

Hospital manages care of the confirmed case (patient), the patient's waste, etc.

Hospital is defined as Tier I with ICU capability and appropriate PPE.

PUI or Confirmed Case's House Hold Contacts

PUI or Confirmed Case's Close Contacts

Figure 2

Response for Suspected Case

- Hospital and ID Epi determine if patient is probable
- No action for household or close contact until determined PUI

Response for Probable Case

- ID Epi, in consultation with CDC, determines that the testing is needed and the sample is sent to a confirmatory lab.
- This person would then be considered a patient under investigation (PUI).

Response for Patient under Investigation (PUI) or Confirmed Case

- Patient will remain in hospital facility under isolation.
- Hospital manages care and is responsible for patient's waste, etc.

Response for Household Contacts

- Wrap-around provisions for up to 42 days (See Figure 3)

- Voluntary quarantine/confinement with possible enforcement during the probable phase.
- Involuntary quarantine/confinement –would require a court order

Response for Close Contacts

- Close contacts are determined by ID Epi with technical assistance from CDC
- Close Contact is defined as:
    - Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g. healthcare personnel, 1st responders) while not wearing recommended personal protective equipment – i.e. standard, droplet, and contact precautions;
    - Having direct brief contact – (e.g. shaking hands) with an EVD patient while not wearing recommended PPE.
    - Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.
- Monitoring by ESF8 (ID Epi) via phone call to determine if the person has gotten ill by 2x/day temperature and symptom monitoring beginning during probable phase

Figure 3: Response for Household Contacts

Step 1 *Step 2* *Step 3* *Ongoing*

House-Hold	Local Solutions	Hazardous Material Cleanup	State
Food and water	Address gaps that cannot be provided by house-hold / family	Organize crew with appropriate PPE.	Daily monitoring by ESF8 (ID Epi) to determine whether house-hold contacts are sick.
Laundry	Behavioral Health consultation via Locally Governed Entities (LGE) (See ICS-205 ESF-8 Behavioral Health Contacts)	Scope: Pick up contaminated items and provide disposal	Intermittent monitoring by ESF6 to determine mass care gaps and local resource solutions.
Medicines/Pharmacy	Faith based support	LSP Emergency Services Unit to develop teams and plan for environmental cleaning inside area. (ESF10)	
Family care items - Diapers, etc.	American Red Cross	Discussion to occur between ID Epi and LSP Emergency Services Unit to include pet waste	

Family to work with ID Epi on how to protect themselves from contaminated items.	VOAD		
Pet care		ESF-10	DHH Public Health Veterinarian & ESF 11 for care and management of pet

Figure 3

Actions Initiated as follows:

- Communication from OPH/Env Epi (ESF8) Section will determine level of confinement for suspect cases and contacts.
- Investigate at hospital; notify CDC of determination of a likely case and collect samples for confirmation.
- Until the sample is confirmed, ESF 8 will not begin contact tracing.
- If sample is confirmed, ESF 8 (and CDC) will start contact tracing.
- As contacts are identified, ID Epi will determine the need to confine.
- OPH/Env Epi will work with Parish to communicate when need to confine is identified.

Direction and Control

In the response to a confirmed case of Ebola in Louisiana, the Governor will activate the State's Emergency Response Plan under the command of the Director of GOHSEP.

Organization and Assignments of Responsibilities

ESF 1

DOTD

- If parish is unable to conduct the following missions, DOTD will:
  - Manage the mission of transporting quarantine candidates of probable Ebola cases to state approved quarantine locations.
  - Manage the mission of transporting medical supplies or Personal Protective Equipment (PPE).
  - Manage the mission of transporting furnishings to quarantine locations **prior to the arrival** of quarantine candidates.

ESF 2

See communications plan ICS 205

ESF 3

DOTD

- Be prepared to assist local, parish, and state officials with traffic management

ESF 4

- Provide local Fire Departments with situational awareness
- Provide local Fire Departments with best practices and protective measures
- Coordinate and provide assistance in response and mitigation

ESF 5

Unified Command Group will convene

GOHSEP

- State EOC will activate to appropriate level
- Conduct parish and regional conference calls to obtain and provide information
- Initiate WebEOC situational reporting and resource requesting from State and parish agencies.

ESF 6

DCFS

- As a contingency, DCFS will Identify 10 foster homes for immediate placement for children if parent(s) are probable/confirmed cases and there is no one else in the household.
- Provide case workers
- Create list of possible needs for quarantined individuals

Louisiana Housing Corporation

- Provide 18 single family dwellings for quarantine families
- Work with Public Service Commission for activation of utilities

Department of Corrections

- Will provide housing units from Corrections Facilities

American Red Cross

- Provide comfort kits to quarantined persons
- Coordinate with VOAD partners on a feeding plan
- Provide funding for prescription medications and medical equipment
- Will work with partner agencies to assist with support of quarantined families in order to handle non-Ebola medical needs

Workforce Commission

- Provide mass feeding support through established contracts (minimum 500 people to activate contracts)

Department of Education
(See Appendix 5 for additional school information)

- Will determine continuity of education of quarantined school children

- DOE continues to disseminate through weekly newsletter all DHH Ebola educational information to the following:
  - Public Schools, Child Care Centers, Private Schools, Charter Schools
- When a student presents with an illness
  I. Nurse or office faculty (if no nurse) will ask the DHH approved targeted questions related to Ebloa by contacting the parent/guardian of the student
  II. If the response is yes
    - The school will notify IDEpi
    - The school will follow instructions per IDEpi
    - The school will notify superintendent's office
- Continuing education of quarantined/isolated student
  I. Work with state/local officials
  II. Provide electronic equipment for learning as needed

ESF 7

DOA

- Establish decontamination and remediation State contract
- Establish body bag State contract
- Establish activity code for tracking expenses
- Issue memorandum(s) to State agencies to track expenditures and report same into WebEOC

GOHSEP

- Execute Decontamination and Remediation contracts
- Execute procurement for other parish or state resource requests as needed

DHH

- Execute contract for body bags

ESF 8

DHH

- Act as overall medical lead for all Ebola cases
- Monitoring of quarantined persons will be conducted by DHH/OPH ID Epi staff
- The sheltering, transportation and care of pets of hospitalized or quarantined contacts will be conducted in facilities and methods approved by and under the authority of the DHH State Public Health Veterinarian
- Educate Hospitals and pre hospital providers regarding treatment protocols, PPE levels, and handling of remains
- Infectious Disease EPI
  - Will notify state agencies of confirmed cases of Ebola
  - Conduct epidemiological investigations
  - Identify contaminated items and provide technical assistance for on scene decontamination

- Bureau of Emergency Medical Services will provide proper direction and level of PPE for responders to potential Ebola related 911 calls

ESF 9

No identified role

ESF 10

LSP

- On site command and control for all decontamination and remediation sites
- Direct and monitor contractor operations from contract executed by GOHSEP
- Remove all persons from contaminated sites as directed by DHH
- Oversee remediation in coordination with DEQ

ESF 11

LDAF

- Provide resource support to ESF8 upon the request of the Public Health Officer
- Follow LDAF'S Livestock Disaster Annex in response to a Livestock event

ESF 12

LPSC

- Work with Louisiana Housing Corporation for utilities activation of 18 reserved single family dwellings for quarantine families
- Work with DOTD/DHH to ensure regulated passenger vehicles for quarantine family transport are available and following all applicable regulations

ESF 13

LSP

- Provide public safety utilizing law enforcement assets
- Provide escorts for transportation

DOJ

- Provide court order for quarantine

ESF 14

No identified role

ESF 15

GOHSEP

- Lead for all public information
- Coordinate with all agency PIOs in order to provide a unified message
  - Key PIOs (GOHSEP, DHH and LSP)

ESF 16

LANG

- Prepare to handle logistics and commodity distribution
- Provide support to other ESFs
- Provide technical expertise assistance on scene

Administration and Finance

State agencies will track all related emergency expenses with supporting documentation.

State agencies will absorb all cost for their statutory and ESF responsibilities and seek supplemental budget and funding as needed.

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Appendix 1: Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients with Known or Suspected Ebola Virus Disease in Louisiana

http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html

Who this is for: Managers of 9-1-1 Public Safety Answering Points (PSAPs), EMS Agencies, EMS systems, law enforcement agencies and fire service agencies as well as individual emergency medical services providers (including emergency medical technicians (EMTs), paramedics, and medical first responders, such as law enforcement and fire service personnel).

What this is for: Guidance for handling inquiries and responding to patients with suspected Ebola symptoms, and for keeping workers safe.

How to use: Managers should use this information to understand and explain to staff how to respond and stay safe. Individual providers can use this information to respond to suspected Ebola patients and to stay safe.

Key Points:

The likelihood of contracting Ebola is extremely low unless a person has direct unprotected contact with the blood or body fluids (like urine, saliva, feces, vomit, sweat, and semen) of a person who is sick with Ebola or direct handling of bats, rodents, or nonhuman primates from areas with Ebola outbreaks.

When risk of Ebola is elevated in their community, it is important for PSAPs to question callers about:

Residence in, or travel to, a country where an Ebola outbreak is occurring;

Signs and symptoms of Ebola (such as fever, vomiting, diarrhea); and

Other risk factors, like having touched someone who is sick with Ebola.

PSAPS should tell EMS personnel this information before they get to the location so they can put on the correct personal protective equipment (PPE) (described below).

EMS staff should check for symptoms and risk factors for Ebola. Staff should notify the receiving healthcare facility in advance when they are bringing a patient with suspected Ebola, so that proper infection control precautions can be taken.

The guidance provided in this document is based on current knowledge of Ebola. Updates will be posted as needed on the ESF 8 SharePoint Website as well as the CDC Ebola webpage. The information contained in this document is intended to complement existing guidance for

healthcare personnel, Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever.

Case Definition for Ebola Virus Disease (EVD)

The CDC's most current case definition for EVD may be accessed here: http://www.cdc.gov/vhf/ebola/hcp/case-definition.html.

Recommendations for 9-1-1 Public Safety Answering Points (PSAPs)

State and local EMS authorities may authorize PSAPs and other emergency call centers to use modified caller queries about Ebola when they consider the risk of Ebola to be elevated in their community (e.g., in the event that patients with confirmed Ebola are identified in the area). This will be decided from information provided by local, state, and federal public health authorities, parish (New Orleans) health department(s), state health department(s), and CDC.

For modified caller queries:

It will be important for PSAPs to question callers and determine if anyone at the incident possibly has Ebola. This should be communicated immediately to EMS personnel before arrival and to assign the appropriate EMS resources. PSAPs should review existing medical dispatch procedures and coordinate any changes with their EMS medical director and with their local public health department.

PSAP call takers should consider screening callers for symptoms and risk factors of Ebola. Callers should be asked if they, or someone at the incident, have fever of greater than 38.6 degrees Celsius or 101.5 degrees Fahrenheit, and if they have additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained bleeding.

If PSAP call takers suspect a caller is reporting symptoms of Ebola, they should screen callers for risk factors within the past 3 weeks before onset of symptoms. Risk factors include:

Contact with blood or body fluids of a patient known to have or suspected to have Ebola;

Residence in–or travel to–a country where an Ebola outbreak is occurring (a list of impacted countries can be accessed at the following link:

http://www.cdc.gov/vhf/ebola/outbreaks/guinea/index.html

Direct handling of bats, rodents, or non-human primates from disease-endemic areas

If PSAP call takers have information alerting them to a person with possible Ebola, they should make sure any first responders and EMS personnel are made confidentially aware of the potential for Ebola before the responders arrive on scene.

If responding at an airport or other port of entry to the United States, the PSAP should notify the CDC Quarantine Station for the port of entry. Contact information for CDC Quarantine Stations can be accessed at the following link:

http://www.cdc.gov/quarantine/quarantinestationcontactlistfull.html

Recommendations for EMS and Medical First Responders, Including Firefighters and Law Enforcement Personnel

For the purposes of this section, "EMS personnel" means pre-hospital EMS, law enforcement and fire service first responders. These EMS personnel practices should be based on the most up-to-date Ebola clinical recommendations and information from appropriate public health authorities and EMS medical direction.

When state and local EMS authorities consider the threat to be elevated (based on information provided by local, state, and federal public health authorities, including the parish (New Orleans) health department(s), state health department(s), and the CDC), they may direct EMS personnel to modify their practices as described below.

Patient assessment

Interim recommendations:

Address scene safety:

If PSAP call takers advise that the patient is suspected of having Ebola, EMS personnel should put on the PPE appropriate for suspected cases of Ebola (described below) before entering the scene.

Keep the patient separated from other persons as much as possible.

Use caution when approaching a patient with Ebola. Illness can cause delirium, with erratic behavior that can place EMS personnel at risk of infection, e.g., flailing or staggering.

During patient assessment and management, EMS personnel should consider the symptoms and risk factors of Ebola:

All patients should be assessed for symptoms of Ebola (fever of greater than 38.6 degrees Celsius or 101.5 degrees Fahrenheit, and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage). If the patient has symptoms of Ebola, then ask the patient about risk factors within the past 3 weeks before the onset of symptoms, including:

Contact with blood or body fluids of a patient known to have or suspected to have Ebola;

Residence in—or travel to— a country where an Ebola outbreak is occurring (a list of impacted countries can be accessed at the following link:

http://www.cdc.gov/vhf/ebola/outbreaks/guinea/index.html

Direct handling of bats, rodents, or non-human primates from disease-endemic areas

Based on the presence of symptoms and risk factors, put on or continue to wear appropriate PPE and follow the scene safety guidelines for suspected case of Ebola.

If there are no risk factors, proceed with normal EMS care.

EMS Transfer of Patient Care to a Healthcare Facility

EMS personnel should notify the receiving healthcare facility when transporting a suspected Ebola patient, so that appropriate infection control precautions may be prepared prior to patient arrival. Any U.S. hospital that is following CDC's infection control recommendations and can isolate a patient in a private room is capable of safely managing a patient with Ebola.

Interfacility Transport

EMS personnel involved in the air or ground interfacility transfer of patients with suspected or confirmed Ebola should wear recommended PPE (described below).

Infection Control

EMS personnel can safely manage a patient with suspected or confirmed Ebola by following recommended isolation and infection control procedures, including standard, contact, and droplet precautions. Particular attention should be paid to protecting mucous membranes of the eyes, nose, and mouth from splashes of infectious material, or self-inoculation from soiled gloves. Early recognition and identification of patients with potential Ebola is critical. An EMS agency managing a suspected Ebola patient should follow these CDC recommendations:

Limit activities, especially during transport that can increase the risk of exposure to infectious material (e.g., airway management, cardiopulmonary resuscitation, use of needles).

Limit the use of needles and other sharps as much as possible. All needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers.

Phlebotomy, procedures, and laboratory testing should be limited to the minimum necessary for essential diagnostic evaluation and medical care.

Use of Personal protective equipment (PPE)

Use of standard, contact, and droplet precautions is sufficient for most situations when treating a patient with a suspected case of Ebola as defined above. EMS personnel should wear:

Gloves

Gown (fluid resistant or impermeable)

Eye protection (goggles or face shield that fully covers the front and sides of the face)

Facemask

Additional PPE might be required in certain situations (e.g., large amounts of blood and body fluids present in the environment), including but not limited to double gloving, disposable shoe covers, and leg coverings.

Pre-hospital resuscitation procedures such as endotracheal intubation, open suctioning of airways, and cardiopulmonary resuscitation frequently result in a large amount of body fluids, such as saliva and vomit. Performing these procedures in a less controlled environment (e.g., moving vehicle) increases risk of exposure for EMS personnel. If conducted, perform these procedures under safer circumstances (e.g., stopped vehicle, hospital destination).

During pre-hospital resuscitation procedures (intubation, open suctioning of airways, cardiopulmonary resuscitation):

In addition to recommended PPE, respiratory protection that is at least as protective as a NIOSH-certified fit-tested N95 filtering face piece respirator or higher should be worn (instead of a facemask).

Additional PPE must be considered for these situations due to the potential increased risk for contact with blood and body fluids including, but not limited to, double gloving, disposable shoe covers, and leg coverings.

If blood, body fluids, secretions, or excretions from a patient with suspected Ebola come into direct contact with the EMS provider's skin or mucous membranes, then the EMS provider should immediately stop working. They should wash the affected skin surfaces with soap and water and report exposure to an occupational health provider or supervisor for follow-up.

Recommended PPE should be used by EMS personnel as follows:

PPE should be worn upon entry into the scene and continued to be worn until personnel are no longer in contact with the patient.

PPE should be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials.

PPE should be placed into a medical waste container at the hospital or double bagged and held in a secure location.

Re-useable PPE should be cleaned and disinfected according to the manufacturer's reprocessing instructions and EMS agency policies.

Instructions for putting on and removing PPE have been published online at http://www.cdc.gov/HAI/prevent/ppe.html and http://www.cdc.gov/vhf/ebola/pdf/ppe-poster.pdf

[PDF - 2 pages].

Hand hygiene should be performed immediately after removal of PPE.

Environmental infection control

Environmental cleaning and disinfection, and safe handling of potentially contaminated materials is essential to reduce the risk of contact with blood, saliva, feces, and other body fluids that can soil the patient care environment. EMS personnel should always practice standard environmental infection control procedures, including vehicle/equipment decontamination, hand hygiene, cough and respiratory hygiene, and proper use of U.S. Food and Drug Administration (FDA) cleared or authorized medical PPE. For additional information, see CDC's Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus.

EMS personnel performing environmental cleaning and disinfection should:

Wear recommended PPE (described above) and consider use of additional barriers (e.g., shoe and leg coverings) if needed.

Wear face protection (facemask with goggles or face shield) when performing tasks such as liquid waste disposal that can generate splashes.

Use an EPA-registered hospital disinfectant with a label claim for one of the non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces. Alternatively, use a freshly prepared (i.e., within 12 hours) 1:50 dilution of household bleach (final working concentration of 100 parts per million or 0.1% hypochlorite solution) that is prepared fresh daily. Disinfectant should be available in spray bottles or as commercially prepared wipes for use during transport.

Spray and wipe clean any surface that becomes potentially contaminated during transport. These surfaces should be immediately sprayed and wiped clean (if using a commercially prepared disinfectant wipe) and the process repeated to limit environmental contamination.

Cleaning EMS Transport Vehicles after Transporting a Patient with Suspected or Confirmed Ebola.

The following are general guidelines for cleaning or maintaining EMS transport vehicles and equipment after transporting a patient with suspected or confirmed Ebola:

EMS personnel performing cleaning and disinfection should wear recommended PPE (described above) and consider use of additional barriers (e.g., rubber boots or shoe and leg coverings) if needed. Face protection (facemask with goggles or face shield) should be worn since tasks such as liquid waste disposal can generate splashes.

Patient-care surfaces (including stretchers, railings, medical equipment control panels, and adjacent flooring, walls and work surfaces) are likely to become contaminated and should be cleaned and disinfected after transport.

A blood spill or spill of other body fluid or substance (e.g., feces or vomit) should be managed through removal of bulk spill matter, cleaning the site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient.

An EPA-registered hospital disinfectant with label claims for viruses that share some technical similarities to Ebola (such as, norovirus, rotavirus, adenovirus, poliovirus) and instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids should be used according to those instructions. Alternatively, a 1:10 dilution of household bleach (final working concentration of 500 parts per million or 0. 5% hypochlorite solution) that is prepared fresh daily (i.e., within 12 hours) can be used to treat the spill before covering with absorbent material and wiping up. After the bulk waste is wiped up, the surface should be disinfected as described in the bullet above.

Contaminated reusable patient care equipment should be placed in biohazard bags and labeled for cleaning and disinfection according to agency policies. Reusable equipment should be cleaned and disinfected according to manufacturer's instructions by trained personnel wearing correct PPE. Avoid contamination of reusable porous surfaces that cannot be made single use.

Use only a mattress and pillow with plastic or other covering that fluids cannot get through. To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, non-fluid-impermeable pillows or mattresses as a regulated medical waste.

Follow-up and/or reporting measures by EMS personnel after caring for a suspected or confirmed Ebola patient

EMS personnel should be aware of the follow-up and/or reporting measures they should take after caring for a suspected or confirmed Ebola patient.

EMS agencies should develop policies for monitoring and management of EMS personnel potentially exposed to Ebola.

EMS agencies should develop sick leave policies for EMS personnel that are non-punitive, flexible and consistent with public health guidance

Ensure that all EMS personnel, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick leave policies.

EMS personnel with exposure to blood, bodily fluids, secretions, or excretions from a patient with suspected or confirmed Ebola should immediately:

Stop working and wash the affected skin surfaces with soap and water. Mucous membranes (e.g., conjunctiva) should be irrigated with a large amount of water or eyewash solution;

Contact occupational health/supervisor for assessment and access to post-exposure management services; and

Receive medical evaluation and follow-up care, including fever monitoring twice daily for 21 days, after the last known exposure. They may continue to work while receiving twice daily fever checks, based upon EMS agency policy and discussion with local, state, and federal public health authorities.

EMS personnel who develop sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an unprotected exposure (i.e., not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with suspected or confirmed Ebola should:

Not report to work or immediately stop working and isolate themselves;

Notify their supervisor, who should notify local and state health departments;

Contact occupational health/supervisor for assessment and access to post-exposure management services; and

Comply with work exclusions until they are deemed no longer infectious to others.

1 http://www.cdc.gov/vhf/ebola/hcp/patient-management-us-hospitals.html

2 http://www.cdc.gov/vhf/ebola/hcp/case-definition.html

3 http://www.cdc.gov/vhf/ebola/hcp/clinician-information-us-healthcare-settings.html

Appendix 2: Guidance for Safe Handling of Human Remains of Ebola Patients in Louisiana Hospitals and Mortuaries

http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html

These recommendations give guidance on the safe handling of human remains that may contain Ebola virus and are for use by personnel who perform postmortem care in Louisiana hospitals and mortuaries. In patients who die of Ebola virus infection, virus can be detected throughout the body. Ebola virus can be transmitted in postmortem care settings by laceration and puncture with contaminated instruments used during postmortem care, through direct handling of human remains without appropriate personal protective equipment, and through splashes of blood or other body fluids (e.g. urine, saliva, feces) to unprotected mucosa (e.g., eyes, nose, or mouth) which occur during postmortem care.

Only personnel trained in handling infected human remains, and wearing PPE, should touch, or move, any Ebola-infected remains.

Handling of human remains should be kept to a minimum.

Autopsies on patients who die of Ebola should be avoided. If an autopsy is necessary, the state health department and CDC should be consulted regarding additional precautions.

Definitions for Terms Used in this Guidance

- Cremation: The act of reducing human remains to ash by intense heat.
- Hermetically sealed casket: A casket that is airtight and secured against the escape of microorganisms. A casket will be considered hermetically sealed if accompanied by valid documentation that it has been hermetically sealed AND, on visual inspection, the seal appears not to have been broken.
- Leak-proof bag: A body bag that is puncture-resistant and sealed in a manner so as to contain all contents and prevent leakage of fluids during handling, transport, or shipping.

Personal protective equipment for postmortem care personnel

Personal protective equipment (PPE): Prior to contact with body, postmortem care personnel must wear PPE consisting of: surgical scrub suit, surgical cap, impervious gown with full sleeve coverage, eye protection (e.g., face shield, goggles), facemask, shoe covers, and double surgical gloves. Additional PPE (leg coverings, apron) might be required in certain situations (e.g., copious amounts of blood, vomit, feces, or other body fluids that can contaminate the environment).

Putting on, wearing, removing, and disposing of protective equipment: PPE should be in place BEFORE contact with the body, worn during the process of collection and placement in body

bags, and should be removed immediately after and discarded as regulated medical waste. Use caution when removing PPE as to avoid contaminating the wearer. Hand hygiene (washing your hands thoroughly with soap and water or an alcohol based hand rub) should be performed immediately following the removal of PPE. If hands are visibly soiled, use soap and water.

Postmortem preparation

Preparation of the body: At the site of death, the body should be wrapped in a plastic shroud. Wrapping of the body should be done in a way that prevents contamination of the outside of the shroud. Change your gown or gloves if they become heavily contaminated with blood or body fluids. Leave any intravenous lines or endotracheal tubes that may be present in place. Avoid washing or cleaning the body. After wrapping, the body should be immediately placed in a leak-proof plastic bag not less than 150 μm thick and zippered closed. The bagged body should then be placed in another leak-proof plastic bag not less than 150 μm thick and zippered closed before being transported to the morgue.

Surface decontamination: Prior to transport to the morgue, perform surface decontamination of the corpse-containing body bags by removing visible soil on outer bag surfaces with EPA-registered disinfectants which can kill a wide range of viruses. Follow the product's label instructions. The visible soil has been removed, reapply the disinfectant to the entire bag surface and allow to air dry. Following the removal of the body, the patient room should be cleaned and disinfected. Reusable equipment should be cleaned and disinfected according to standard procedures. For more information on environmental infection control, please refer to "Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus" (http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html).

Individuals driving or riding in a vehicle carrying human remains: PPE is not required for individuals driving or riding in a vehicle carrying human remains, provided that drivers or riders will not be handling the remains of a suspected or confirmed case of Ebola, and the remains are safely contained and the body bag is disinfected as described above.

Mortuary care

Do not perform embalming. The risks of occupational exposure to Ebola virus while embalming outweighs its advantages; therefore, bodies infected with Ebola virus should not be embalmed.

Do not perform autopsies.

Do not open the body bags.

Do not remove remains from the body bags. Bagged bodies should be placed directly into a hermetically sealed casket.

Mortuary care personnel should wear PPE listed above (surgical scrub suit, surgical cap, impervious gown with full sleeve coverage, eye protection (e.g., face shield, goggles), facemask, shoe covers, and double surgical gloves) when handling the bagged remains.

In the event of leakage of fluids from the body bag, thoroughly clean and decontaminate areas of the environment with EPA-registered disinfectants which can kill a broad range of viruses in accordance with label instructions. Reusable equipment should be cleaned and disinfected according to standard procedures. For more information on environmental infection control, please refer to "Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus" (http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html).

Disposition of Remains

Remains should be cremated or buried promptly in a hermetically sealed casket.

Once the bagged body is placed in the sealed casket, no additional cleaning is needed unless leakage has occurred.

No PPE is needed when handling the cremated remains or the hermetically sealed closed casket.

Transportation of human remains

Transportation of remains that contain Ebola virus should be minimized to the extent possible.

All transportation, including local transport, for example, for mortuary care or burial, should be coordinated with relevant local and state authorities in advance.

Interstate transport should be coordinated with CDC by calling the Emergency Operations Center at 770-488-7100. The mode of transportation (i.e., airline or ground transport), must be considered carefully, taking into account distance and the most expeditious route. If shipping by air is needed, the remains must be labeled as dangerous goods in accordance with Department of Transportation regulations (49 Code of Federal Regulations 173.196).

Transportation of remains that contain Ebola virus outside the United States would need to comply with the regulations of the country of destination, and should be coordinated in advance with relevant authorities.

References

CDC. Medical Examiners, Coroners, and Biologic Terrorism A Guidebook for Surveillance and Case Management. MMWR 2004;53(RR08);1-27. (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5308a1.htm)

Appendix 3: Handling Ebola Remains - ESF 8 and Louisiana Coroner's Association

This is a list of issues that are being further considered by ESF 8 in coordination with the Louisiana Coroners Association. A Statewide meeting of coroners will be held on November 1, 2014 in Baton Rouge, Louisiana, and the president of the association has agreed to allow State ESF 8 to address fatality management of Ebola victims with all state coroners. The following list contains topics to be discussed. Louisiana will use the CDC guidance as a baseline, and the following issues will be used to identify any potential gaps in resources and/or planning. Gaps identified will be referred to a small planning cell for protocol development, then reviewed and distributed by the Coroner's Association.

1. Coordination between Coroner and Hospitals for Body Handoff

a. **Preparation of Remains at Hospital**

i. Packaging Protocol

ii. Preparation of Personnel

iii. Liaison with the Parish Coroner

iv. Handling Medical Waste

Discussion: Follow CDC Guidance on Safe Handling of Human Remains

b. **Transportation Protocols**

i. Transporters

ii. Preparation

iii. Handling and Movement Protocols

iv. Managing PPE Waste

v. Route Planning

vi. Internal in the Hospital

vii. External to the Destination

viii. Vehicle Preparation

1. Preparation

2. Decontamination

Discussion: Survey Coroners about transportation resources, contractors and guidelines. Also explore MOUs between the larger parishes which are well-resourced and the smaller parishes.

c. Preparation of Receiving Facilities

i. Preparation

ii. Decontamination

Discussion: Discuss at November 1 state meeting of the Coroner's Association

2. Interface with Families

a. Hospital Duties

b. Coroner Duties

c. Funeral Home/Crematory Duties

Discussion: Primary interface with the families will occur at the hospital by hospital staff before death. After death, the Coroner's Investigators typically handle family coordination.

3. Communication and Interface with Funeral Homes (Crematories)

a. Preparation of Funeral Homes

b. Transportation Protocols

Discussion: Discuss at the November 1 Coroner's Association Meeting

4. Burial and/or Cremation Procedures

a. Licensed Crematories

i. Preparations

ii. Handling of remains

iii. Disposal of cremains

Discussion: Follow CDC Guidance on Safe Handling of Human Remains. Also obtain information on the following:

- Contact the Louisiana State Board of Embalmers & Funeral Directors (LSBEFD) for data about funeral homes and crematories. Update: the database for the Board has been down for several days, but they will forward the information as soon as they can access their server. In the interim, the following data was provided about licensed Louisiana resources:
    - 404 funeral homes in the state,
    - 24 crematories with 103 licensed operators qualified to cremate

Discussion: ESF 8 will obtain the data from the LSBEFD as soon as available. In the interim, with the data available, we will create a rough map of the location of these resources along with a throughput simulation model based on industry benchmarks, such as average time to complete cremation, transportation times, workloads and capacities, etc. This will be made available for the November 1st Coroner's Association Meeting.

In conclusion, the President of the Association agreed to the following:

- Give ESF 8 time during the meeting to address the coroners in attendance about potential protocols and other issues

- Assist in finalizing a draft protocol for review by the association members

- Participate in a small fatality planning cell with ESF 8 staff and other subject matter experts.

- Provide any templates, protocols and operating guidelines already developed for handling Ebola victim remains (or any remains where an infectious disease was the cause of death.)

Appendix 4: Recommendations for Pets in Louisiana

- If there is a pet in the home of an Ebola patient, CDC recommends that public health officials in collaboration with a veterinarian, evaluate the animal's risk of exposure (close contact and exposure to blood or bodily fluids of an Ebola patient).

- The exposed pet should be monitored, in collaboration with a veterinarian, with limited contact, for a minimum of three weeks following the exposure.

The following is information regarding animals and Ebola:

Dogs and Ebola virus

- There has never been a documented case in a dog. No dog has been found to be ill with the virus.

- There have been no reports of pets playing a role in transmission of Ebola to humans.

- Dogs in areas where Ebola virus circulates have been found to produce antibodies against the disease, indicating that the dogs were infected with the virus or, at minimum, were exposed to the extent that the immune system was stimulated. Nevertheless it does not appear that dogs get sick when exposed.

- The virus has never been isolated from a dog, only antibodies to the virus have been discovered in dogs. This also indicates that dogs are only temporarily infected, or that the virus does not infect the dog, but stimulates immunity.

- In areas where Ebola circulates in human populations, dogs are likely exposed by consuming parts of the carcasses of animals that are infected (non-human primates such as gorillas and chimpanzees, wild ruminants such as duikers) or by licking vomit or other bodily excretions and secretions from human patients.

- Because dogs have not been discovered to be sick from the virus, but do produce antibodies to the disease, it is thought dogs may temporarily be infected but not present with signs of illness.

- Although dogs do not get sick, they may be able to excrete the virus in urine, feces and saliva for a short period of time. The dogs may transmit the virus through licks, biting and grooming (due to the dog's coat being contaminated with body fluids).

- There is some evidence in endemic areas that dogs may also be exposed to an unknown natural host in the environment (at present, bats and small rodents are the most likely candidates). Researchers cannot rule out the possibility that this exposure could be due to aerosol or droplet transmission.

• Due to the unknowns above, dogs must be considered during any response to an Ebola outbreak or when addressing individual human cases of Ebola in areas where the disease has not been known to circulate historically.

Pigs and Ebola:

- Swine can be infected with the virus and have played a role in at least one outbreak.
- Swine have been shown experimentally to be able to infect non-human primates through large droplet transmission. Swine are extremely efficient producers of large respiratory droplets.

Appendix 5: LA Handbook for School Administrators

A. The local superintendent or chief school officer may dismiss any or all schools due to emergency situations, including any actual or imminent threat to public health or safety which may result in loss of life, disease, or injury; an actual or imminent threat of natural disaster, force majeure, or catastrophe which may result in loss of life, injury or damage to property; and, when an emergency situation has been declared by the governor, the state health officer, or the governing authority of the school.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:416.16 and R.S. 17:154.1.
HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1262 (June 2005), amended LR 39:3258 (December 2013), LR 40:

B. A student who has been quarantined by order of state or local health officers following prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, and is temporarily unable to attend school, shall be provided any missed assignments, homework, or other instructional services in core academic subjects in the home, hospital environment, or temporary shelter to which he has been assigned. The principal, with assistance from the local superintendent and the LDE, shall collaborate with state and local health officers and emergency response personnel to ensure the timely delivery or transmission of such materials to the student.

C. Elementary students shall be in attendance a minimum of 60,120 minutes (equivalent to 167 six-hour days) a school year. In order to be eligible to receive grades, high school students shall be in attendance a minimum of 30,060 minutes (equivalent to 83.5 six-hour school days), per semester or 60,120 minutes (equivalent to 167 six-hour school days) a school year for schools not operating on a semester basis.

- Students in danger of failing due to excessive absences may be allowed to make up missed time in class sessions held outside the regular class time. The make-up sessions must be completed before the end of the current semester and all other policies must be met.

D. Each LEA shall develop and implement a system whereby the principal of a school, or his designee, shall notify the parent or legal guardian in writing upon on or before a student's third unexcused absence or unexcused occurrence of being tardy, and shall hold a conference with such student's parent or legal guardian. This notification shall include information relative to the parent or legal guardian's legal responsibility to enforce the student's attendance at school and the civil penalties that may be incurred if the student is determined to be habitually absent or habitually tardy. The student's parent or legal guardian shall sign a receipt for such notification.

E. Tardy shall include but not be limited to leaving or checking out of school unexcused prior to the regularly scheduled dismissal time at the end of the school day but shall not include reporting late to class when transferring from one class to another during the school day.

F. Exceptions to the attendance regulation shall be the enumerated extenuating circumstances below that are verified by the Supervisor of Child Welfare and Attendance or the school

principal/designee where indicated. These exempted absences do not apply in determining whether a student meets the minimum minutes of instruction required to receive credit:

1. extended personal physical or emotional illness as verified by a physician or nurse practitioner licensed in the state;

2. extended hospital stay in which a student is absent as verified by a physician or dentist;

3. extended recuperation from an accident in which a student is absent as verified by a physician, dentist, or nurse practitioner licensed in the state;

4. extended contagious disease within a family in which a student is absent as verified by a physician or dentist licensed in the state; or

5. quarantine due to prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, as ordered by state or local health officials; or

6. observance of special and recognized holidays of the student's own faith;

7. visitation with a parent who is a member of the United States Armed Forces or the National Guard of a state and such parent has been called to duty for or is on leave from overseas deployment to a combat zone or combat support posting. Excused absences in this situation shall not exceed five school days per school year;

8. absences verified and approved by the school principal or designee as stated below:

a. prior school system-approved travel for education;

b. death in the immediate family (not to exceed one week); or

c. natural catastrophe and/or disaster.

G. For any other extenuating circumstances, the student's parents or legal guardian must make a formal appeal in accordance with the due process procedures established by the LEA.

H. Students who are verified as meeting extenuating circumstances, and therefore eligible to receive grades, shall not receive those grades if they are unable to complete makeup work or pass the course.

I. Students participating in school-approved field trips or other instructional activities that necessitate their being away from school shall be considered to be present and shall be given the opportunity to make up work.

J. If a student is absent from school for 2 or more days within a 30-day period under a contract or employment arrangement to render artistic or creative services for compensation as set forth in the Child Performer Trust Act (R.S. 51:2131 et seq.) the employer shall employ a certified teacher, beginning on the second day of employment, to provide a minimum of three education instruction hours per day to the student pursuant to the lesson plans for the particular student as provided by the principal and teachers at the student's school. There must be a teacher to student ratio of one teacher for every 10 students.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:112, R.S. 17:221.3-4, R.S. 17:226.1, and R.S. 17:233.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1273 (June 2005), amended LR 32:546 (April 2006), LR 32:1030 (June 2006), LR 33:2351 (November 2007), LR 35:641 (April 2009), LR 35:1097 (June 2009), LR 35:1475

(August 2009), LR 36:482 (March 2010), LR 36:1224 (June 2010), LR 37:1126 (April 2011), LR 37:2132 (July 2011), LR 38:1000 (April 2012), LR 38:1225 (May 2012), LR 38:1399 (June, 2012), LR 39:2205 (August 2013), LR 40:

Communicable Disease Control

A. The LDE will work cooperatively with the Louisiana Department of Health and Hospitals for the prevention, control and containment of communicable diseases in schools and shall assist in the dissemination of information relative to communicable diseases to all school governing authorities, including but not limited to information relative to imminent threats to public health or safety which may result in loss of life or disease.

B. Students are expected to be in compliance with the required immunization schedule.

1. The principal is required under R.S. 17:170 to exclude children from school attendance who are out of compliance with the immunizations required by this statute.

2. School personnel will cooperate with public health personnel in completing and coordinating all immunization data, waivers and exclusions, including the necessary Vaccine Preventable Disease Section's school ionization report forms (EPI-11, 11/84) to provide for preventable communicable disease control.

C. The superintendent may exclude a student or staff member for not more than five days, or the amount of time required by state or local public health officials, from school or employment when reliable evidence or information from a public health officer or physician confirms him/her of having a communicable disease or infestation that is known to be spread by any form of casual contact and is considered a health threat to the school population. Such a student or staff member may be excluded unless the state or local public health officers determine the condition is no longer considered contagious.

Appendix 6: DRAFT Protocol for Dog Isolation (*As of 10/14/14*) after Exposure to a Human with Suspected or Confirmed Ebola Virus Infection

Disclaimer All situations involving pets and possible Ebola exposure are unique. No protocol can address every situation that might occur. The intent of this protocol is to provide guidance for the most common scenarios, based on the latest scientific evidence and recommendations from national organizations. Questions regarding animals and Ebola or this protocol may be directed to Gary Balsamo, DVM, MPH, state public health veterinarian, Louisiana Department of Health and Hospitals (gary.balsamo@la.gov; 504-568-8315) or by 800-256-2748 (24/7).

Background: The ongoing epidemic of Ebola in West Africa has raised several questions about how Ebola affects the animal population, particularly pets. Though several scientists have looked at this, many questions still need to be answered about Ebola and animals. Scientists do not know where the virus originates, but the natural host of Ebola is thought to be fruit bats. At this time, only mammals are known to become infected with Ebola virus. In addition to humans, natural infection in Africa has only been detected in bats, non-human primates, and forest duikers (an African antelope). In Ebola outbreaks, illness in dogs has not been found, and dogs have not been found to be a contributor to disease transmission.

At this time, there have been no reports of dogs or cats becoming sick with Ebola or of being able to spread Ebola to people or animals. Even in areas in Africa where Ebola is present, there have been no reports of dogs or cats becoming sick with Ebola. The chances of a dog being exposed to Ebola virus in the US is very low and would require close contact with bodily secretions of a person with symptoms of Ebola infection. We do not yet know whether or not a pet's body, feet, or fur can act as a fomite to transmit Ebola to people or other animals. It is important to keep people and animals away from blood or body fluids of a person with symptoms of Ebola infection.

If a Pet is in the Home of a Suspect or Confirmed Ebola Patient

1. Collect the following identifying information on the pet:
    - Species (i.e. dog, cat)
    - Breed
    - Sex and Spay/Neuter status
    - Age
    - Markings (Take multiple photos of the dog to capture markings and unique identifiers)
    - Other identifying characteristics
    - Vaccination history, most importantly rabies vaccination details
    - Medical history/need for medications
    - Microchip number (if no microchip and quarantine/confinement is required, consider requiring microchip to ensure that correct dog is monitored in quarantine or home confinement) All dogs and cats that will be quarantined, examined or treated at an approved veterinary hospital or other quarantine facility could be

required to have an implanted electronic microchip. The microchip should be obtained from your veterinarian and must be working.
    - Any other information specifically required by the state/jurisdiction where the dog is located or to be quarantined.
    - Contact information for alternate decision maker on pet(s) in event owner is unavailable to make decisions.

2. Public health officials in collaboration with the state public health veterinarian should evaluate the pet's risk of exposure and transmission including the following:
    - Close contact with human Ebola suspect patient since the onset of the patient's symptoms, including sitting in lap, being cuddled, being kissed, licking suspect patient, sleeping in bed with suspect patient, other types of contact with suspect patient; questions should be asked for the time period since the suspect patient onset began
    - Exposure to blood or body fluids of an Ebola patient (including but not limited to urine, saliva, sweat, feces, and vomit); this includes licking, consuming, or walking through any of these fluids for any reason
    - Clinical history
        - Recent history of decreased appetite, fever, vomiting, diarrhea, lethargy, or other symptoms) since the onset of the Ebola patient's symptoms
        - Medical history in the last year, including history of gastrointestinal illness or bleeding disorders
    - Other human or animal contacts since the onset of the Ebola patient's symptoms (timing and nature of interaction)
        - Presence of other humans or animals in the household
        - Contact with other people or animals:
            - Walks
            - Visits to dog parks
            - Visit to groomer
            - Visit to animal clinic
            - Other outings
        - Is this a therapy, assistance, service, or working animal?
    - Any additional information that might be helpful to evaluate the pet's risk of exposure and potential transmission

3. Once the relevant information is collected, a consultation will be made between relevant state (& local) public health authorities and CDC to determine if the animal has had a risk of exposure to Ebola, and whether confinement is warranted. A state health official should contact the CDC Emergency Operations Center at 770-488-7100 (available 24/7)

4. If the animal in question is a species not covered by this protocol, it will be handled on a case by case basis, in collaboration with local, state, and federal human and animal health officials.

Guidance for the Confinement of a Pet

In the event that confinement is required, the state public health veterinarian will act as the point of contact for confinement of the pet. Ideally confinement should begin within 48 hours after the first contact with the symptomatic patient. Based on experimental studies in other species, the minimum incubation period is 48 hours before an animal becomes viremic.

In the event that confinement of a pet is needed, the following criteria should be met:

- The animal was not a stray or free-roaming animal at the time of the potential exposure. If the animal was a stray and is not available in the home, the state public health veterinarian shall work in conjunction with local animal control officials to identify and capture the animal.

- **Transportation of animal:**
  - Individual(s) removing animal must be in full PPE
  - Collar, clothing etc. to be removed from the animal
  - Only the animal is to be removed from premise
  - Animal placed in new crate outside of home
  - Transport in open air vehicle or in vehicle with back area closed off from driver[1]
  - Lock placed on crate enclosing animal
  - Cleaning and disinfection of vehicle after transport

- **Confinement facility/enclosure:**
  - Minimum of two physical containment levels (i.e., crate/kennel housed in secured facility)
  - Secure primary enclosure (for example, a kennel or crate) to prevent escape (for example, no climbing over or digging out) and approved by the state public health veterinarian
  - Facility should
    - Exclude access by other animals (domestic or wild) or unauthorized personnel
    - Allow animal to remain clean and dry
    - Protect animal from harm
    - Place for eating, drinking, urinating, defecating
  - Confinement shall be subject to additional conditions specified by the designated public health official to protect the public health and animal welfare regulations.

- **Caretaker:**
  - Be limited to as few individuals as possible (minimum of two)
  - Have experience handling animals (appropriate species)
  - Be appropriately trained on PPE, and wear PPE when caring for the animal, in its enclosure, or handling waste material
    - PPE shall consist of, at a minimum
      - Gloves
      - Tyvek suit with foot covers
      - Goggles or face shield

        - N-95 mask
    - Perform proper hand-hygiene prior to leaving enclosure
- Caretaker voluntarily self-monitor for fever twice daily
    - Report a fever >100.4 F to designated public health authority
- Report any symptoms of illness to the designated public authority.

- **Health monitoring of animal:**
    - Direct contact with the animal's body fluids and waste must be limited during the confinement period.
    - The state public health veterinarian, or a veterinarian or veterinary technician designated by the state public health veterinarian will be responsible for oversight of the animal's care and confinement.
        - The veterinarian or veterinary technician should be appropriately trained on PPE, and wear PPE when caring for the animal, in its enclosure, or handling waste material (as above)
        - The veterinarian or veterinary technician should be on call and available over the course of the confinement period
    - As a precaution, and based on what we know about humans, an exposed pet should be monitored, in collaboration with a public health veterinarian as outlined above for a minimum of 21 days following the last date of exposure to the symptomatic Ebola patient. The confinement period may need to be extended based on the progression of the situation.
        - At this time, there are no known clinical signs of Ebola in dogs.
        - The dog should be monitored for general signs of illness.
        - Additionally, other potential signs of illness including decreased appetite, lethargy, vomiting, and diarrhea should be closely monitored.
    - During the confinement period, the animal's caretaker must monitor the animal's behavior and health status and immediately notify the designated veterinarian. The veterinarian will determine if the designated public health official should be notified.
        - Only if the dog appears to be ill, outside of its normal health status, use a digital thermometer with a probe cover to take a rectal temperature to monitor for fever (fever in dogs is >102.5 F).
    - Any required maintenance medicine during the confinement period should be given by indirect method only (no injections or per os).
    - In the case of an animal developing an unrelated condition, the situation would be addressed on case-by-case basis, based on assessment by the designated veterinarian in consultation with the state public health veterinarian.

- **Waste disposal:**
    - Primary containment needs to be cleaned a minimum of once daily
    - Collect of waste, soiled pads/linens should be collected in heavy plastic bag that is secured in rigid plastic tub
    - Transportation of feces, urine, and soiled linens or other potentially hazardous materials should be treated as Category A medical waste.
    - Individual(s) handling waste disposal should be trained to use PPE as outlined above and trained on how to securely handle potentially hazardous waste.

- **At the end of the confinement period all linens, dog beds, and other textiles used in the confinement facility must be discarded as medical waste.**

Appendix 7: Louisiana Department of Health and Hospitals Guidance for Law Enforcement, Fire Services and 9-1-1 for Management of Persons with Known or Suspected Ebola Virus Disease

Kathy H. Kliebert

State of Louisiana

Department of Health and Hospitals

October 13, 2014

Louisiana Department of Health and Hospitals Guidance for Law Enforcement, Fire Services and 9-1-1 for Management of Persons with Known or Suspected Ebola Virus Disease

This guidance has been adapted from Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients with Known or Suspected Ebola Virus Disease in the United States.

Additional necessary information can be found on the Centers for Disease Control and Preventions (CDC) website http://www.cdc.gov/vhf/ebola/index.html The posters for the Sequence for Putting On and Removing Personal Protective Equipment (PPE) at http://www.cdc.gov/vhf/ebola/pdf/ppe-poster.pdf and What You Need To Know About Ebola at http://www.cdc.gov/vhf/ebola/pdf/what-need-to-know-ebola.pdf include critical information which should be shared extensively.

This guidance is intended for handling inquiries and responding safely to persons with known or suspected Ebola. The intended audience is law enforcement, fire service and 911 organizations, as well as individual law enforcement officers, fire service and 911 personnel. Managers should use this guidance to understand and explain to their staff how to respond and stay safe. Individuals can use this information to respond safely to persons with known or suspected Ebola.

Key Points:

The likelihood of contracting Ebola is extremely low, unless a person has direct unprotected contact with the blood or body fluids (like urine, saliva, feces, vomit, sweat, and semen) of a

person who is sick (showing symptoms) with Ebola, or direct handling of bats or nonhuman primates from areas with Ebola outbreaks. People who are not showing symptoms are not contagious.

Early recognition and identification of person with potential Ebola is critical for individuals and communities.

When risk of Ebola is elevated, it is important for 911 Operators in Louisiana, also known as Public Safety Answering Points (PSAPs) to question callers about:

- Residence in, or travel to, a country where an Ebola outbreak is occurring
- Signs and symptoms of Ebola (such as fever, vomiting, diarrhea)
- Other risk factors for Ebola, such as contact with someone who is sick with Ebola or has had recent residence in, or travel to, a country where an Ebola outbreak is occurring

911 Operators should tell responders this information before they get to the location, so responders can put on personal protective equipment (described below).

Law enforcement and fire service personnel should contact EMS for evaluation of a person with symptoms of Ebola.

In addition, responders should notify the receiving healthcare facility in advance, so proper infection control precautions can be taken.

The guidance provided in this document is based on current knowledge of Ebola. Updates will be provided as needed. The information contained in this document is intended to complement existing guidance for healthcare personnel, Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Virus Disease in U.S. Hospitals.

Background

The current Ebola outbreak in West Africa has increased the possibility of patients with Ebola traveling from the affected countries to the United States. The CDC and the Texas Department of State Health Services remain confident that wider spread in the community from the patients in Texas can be prevented with public health measures.

Initial signs and symptoms of Ebola include sudden fever, chills, and muscle aches, diarrhea, nausea, vomiting, and abdominal pain occurring after about 5 days. Other symptoms such as chest pain, shortness of breath, headache, or confusion, may also develop. Symptoms may become increasingly severe and may include jaundice (yellow skin), severe weight loss, mental confusion, bleeding inside and outside the body, shock, and multi-organ failure.

Ebola is often a fatal disease and care should be taken when coming in direct contact with a recent traveler from a country with an Ebola outbreak that has symptoms of Ebola. The initial signs and symptoms of Ebola are similar to many other more common diseases found in West Africa (such as malaria and typhoid). Ebola should be considered in anyone with fever who has traveled to, or lived in, an area where Ebola is present.

The incubation period for Ebola, from exposure to when signs or symptoms appear, ranges from 2 to 21 days (most commonly 8-10 days). Any Ebola patient with signs or symptoms of illness should be considered infectious. Ebola patients without symptoms are not contagious. The prevention of Ebola includes actions to avoid exposure to blood or body fluids of infected patients through contact with skin, mucous membranes of the eyes, nose, or mouth, or injuries with contaminated needles or other sharp objects.

Respiratory droplets carrying infectious pathogens are generated when an infected person coughs, sneezes, or talks, generally traveling only short distances. The nose, eyes and mouth are susceptible portals of entry, necessitating facial protection. Historically, the area of defined risk has been a distance of <3 feet around the patient and is based on epidemiologic and simulated studies of selected infections.

Responders have a vital role in responding to requests for help and providing emergency care to patients. Unlike patient care in the controlled environment, assistance provided in an uncontrolled environment, possibly in a very small space and frequently requires rapid decision-making and interventions with limited information. Responders are frequently unable to determine an individual's history before having to administer emergency care. Coordination among 9-1-1 Public Safety Answering Points (PSAPs) and responders is important when responding to persons with suspected Ebola.

Recommendations for Public Safety Answering Points (PSAPs) and 911 Systems

Organizations may authorize 911 systems, other emergency call centers and PSAPs to use modified caller queries about Ebola when the risk of Ebola is elevated.

For modified caller queries:

It will be important for 911 system operators to question callers and determine if anyone at the incident possibly has Ebola. This should be communicated immediately to responders before arrival and to assign the appropriate resources, including EMS. 911 systems should review existing medical dispatch procedures. DHH is available to consult with PSAP on the development of algorithm for PSAPs.

Callers should be asked if they, or someone at the incident, have fever of greater than 101.5 degrees, and if they have additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained bleeding.

If call takers suspect a caller is reporting symptoms of Ebola, they should screen callers for risk factors within the past 3 weeks before onset of symptoms. Risk factors include:

- Contact with blood or body fluids of a person known or suspected of having Ebola
- Residence in–or travel to–a country where an Ebola outbreak is occurring (a list of impacted countries can be accessed at the following link: http://www.cdc.gov/vhf/ebola/outbreaks/guinea/index.html)
- Direct handling of bats or nonhuman primates from disease-endemic areas

If call takers have information alerting them to a person with possible Ebola, they should make sure all responders are made confidentially aware of the potential for Ebola before the responders arrive on scene.

If responding at an airport or other port of entry to the United States, the PSAP or 911 System should notify the CDC Quarantine Station for the port of entry. Contact information for CDC Quarantine Stations can be accessed at the following link:
http://www.cdc.gov/quarantine/quarantinestationcontactlistfull.html

Recommendations for First Responders, Including Law Enforcement and Fire Service Personnel

Assessment Recommendations

Address scene safety:

If call takers advise that the person is suspected of having Ebola, consider modifying usual activities.

Responders should avoid physical contact and remaining a safe distance, greater than 3 feet from the person.

Responders should put on the PPE appropriate for suspected cases of Ebola (described below) before entering an area where physical contact is anticipated and upon entry into a potentially contaminated scene.

The suspected person should be kept separate from others, as much as possible.

Use caution when approaching a person with Ebola. Advanced illness can cause delirium, with erratic behavior that can place EMS personnel at risk of infection, e.g., flailing or staggering.

Based on the presence of symptoms and risk factors, put on or continue to wear appropriate PPE and follow the scene safety guidelines for suspected case of Ebola.

If there are no risk factors, proceed with normal operations.

EMS can provide safe transport of persons suspected of Ebola. If EMS encounters a suspected or potential Ebola case, the EMS provider should immediately call 1-800-256-2748. If possible, this number should be contacted before the patient is transported. The hotline is staffed 24-hours by an epidemiologist from the Louisiana Department of Health and Hospitals.

Responders should notify the receiving healthcare facility when transporting a suspected Ebola patient, so that appropriate infection control precautions may be prepared prior to patient arrival.

Any U.S. hospital that is following CDC's infection control recommendations and can isolate a patient in a private room is capable of safely managing a patient with Ebola. EMS personnel can safely manage a patient with suspected or confirmed Ebola by following recommended isolation and infection control procedures, including standard, contact, and droplet precautions.

Use of Personal Protective Equipment (PPE)

For contact with a known or suspected case of Ebola, responders should wear:

- **Gown (fluid resistant or impermeable)**
- **Mask or respirator**
- **Goggles or face shield**
- **Disposable medical gloves**

Additional PPE might be required in certain situations (e.g., large amounts of blood and body fluids present in the environment), including but not limited to double gloving, disposable shoe covers, and leg coverings.

Appropriate use requires the correct sequence for putting on PPE. PPE should be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials. Guidance for the proper technique and sequence for the donning and removal of PPE can be found at: http://www.cdc.gov/vhf/ebola/pdf/ppe-poster.pdf.

Recommended PPE and activities for responders:

- PPE should be worn when:
  - Anticipating physical contact with a person with known or suspected Ebola
  - Conducting activities within 3 feet of a person with known or suspected Ebola
  - Upon entry into a potentially contaminated areas
- PPE should be worn until responders are no longer in physical contact with the patient.

- PPE should be *carefully removed without contaminating one's eyes, mucous membranes, or clothing* with potentially infectious materials.
- Hand hygiene should be performed immediately after removal of PPE.
- PPE should be placed into a medical waste container at the hospital or double bagged and held in a secure location.
- Report need for environmental cleaning

Resuscitation

It is highly unlikely a member of fire or police would be asked to assist in the resuscitation of a potential Ebola patient, however, this process is outlined below. Resuscitation procedures frequently result in a large amount of body fluids, such as saliva and vomit. Perform these procedures with extreme caution.

During cardiopulmonary resuscitation:

In addition to recommended PPE, respiratory protection that is at least as protective as a NIOSH-certified fit-tested N95 filtering facepiece respirator or higher should be worn (instead of a facemask).

Additional PPE must be considered for these situations due to the potential increased risk for contact with blood and body fluids including, but not limited to, double gloving, disposable shoe covers, and leg coverings.

If blood, body fluids, secretions, or excretions from a person with suspected Ebola come into direct contact with the responder's skin or mucous membranes, then the responder should immediately stop working. They should wash the affected skin surfaces with soap and water and report exposure to an occupational health provider or supervisor for follow-up.

Enforcement of isolation or quarantine

Professionals tasked to assist in the protection of individuals in isolation and/or quarantine will be assisted by both healthcare and law enforcement individuals, and will play a supportive role as part of an overall management team.

- Isolation: A person symptomatic with the disease kept isolated from others usually in a medical setting (hospital), and treated by persons wearing personal protective equipment.
- Quarantine (confinement): A non-symptomatic person who has potentially been exposed to the disease; confined for the duration of the incubation period which is 21 days for Ebola, with close monitoring.

Responders with the potential for contact with a symptomatic isolated patient should wear PPE as outlined above in Use of Personal Protective Equipment.

Follow-up and/or reporting measures by responders after contact with a known or suspected person with Ebola:

- Personnel should be aware of the follow-up and/or reporting measures they should take after contact with a suspected or confirmed Ebola patient.
- Agencies should develop policies for monitoring and management of EMS personnel potentially exposed to Ebola.
- Agencies should develop sick leave policies for EMS personnel that are non-punitive, flexible and consistent with public health guidance.
- Ensure that all personnel are aware of the sick leave policies.

Responders with exposure to blood, bodily fluids, secretions, or excretions from a person with known or suspected Ebola should immediately:

- Stop working and wash the affected skin surfaces with soap and water. Mucous membranes (e.g., conjunctiva) should be irrigated with a large amount of water or eyewash solution.
- Contact occupational health/supervisor for assessment and access to post-exposure management services.
- Receive medical evaluation and follow-up care, including fever monitoring twice daily for 21 days, after the last known exposure. They may continue to work while receiving twice daily fever checks, based upon agency policy and discussion with public health authorities.

Responders who develop sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an unprotected exposure (i.e., not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with suspected or confirmed Ebola should:

- Not report to work or immediately stop working and isolate themselves.
- Notify their supervisor, who should notify local and state health departments.
- Contact occupational health/supervisor for assessment and access to post-exposure management services.
- Comply with work exclusions until they are deemed no longer infectious to others.

Contact occupational health/supervisor for assessment and access to post-exposure management services; and comply with work exclusions until they are deemed no longer infectious to others.

Contact supervisor for potentially contaminated vehicles, equipment, etc. Environmental infection control requires expertise for safe cleaning.

Summary

Louisiana Call Taker/911 systems should:

- Use a checklist to screen callers which includes:
  - Flu Like Symptoms
  - Travel history related an Ebloa outbreak
  - Contact with person suspected or known to have Ebola
- Notify responders before arrival of persons suspected of Infectious Disease to limit exposure to patient.

Louisiana first responders should:

- Put on PPE before arrival at the scene
- Limit exposure to suspected cases
- Safely remove PPE
- Secure potentially contaminated PPE
- Notify hospitals regarding the transport of persons suspected of Ebola
- Report contact to supervisor for administrative procedures
- Follow organizational guidelines for post-exposure decontamination

Terms and Definitions

CDC
Centers for Disease Control and Prevention

Close Contact

a) Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time 9 e.g. healthcare personnel, household members) while not wearing recommended personal protective equipment-i.e. standard, droplet, and contact precautions.

b) Having direct brief contact-(e.g. shaking hands) with an EVD patient while not wearing recommended PPE.

Confirmed Case
Positive PCR lab test results from the CDC

Contact Tracing
Conducted by ID Epi Team and CDC Team; finding everyone who comes in direct contact with a sick Ebola patient

DHH
Department of Health and Hospitals

DRC
Disaster Response Coordinator

ESF
Emergency Support Function

EUA
Emergency Use Authorization

EVD
Ebola Virus Disease

GOHSEP
Governor's Office of Homeland Security and Emergency Preparedness

Hazmat
Hazardous Materials

HHS
Health and Human Services

ID Epi
Infectious Disease Epidemiology

Isolation
Symptomatic; and in isolated setting in a medical setting or in a home-setting

LRN
Laboratory Response Network

LSBEFD
Louisiana State Board of Embalmers & Funeral Directors

LSP
Louisiana State Police

OPH
Office of Public Health

OHSEP
Office of Homeland Security and Emergency Preparedness

Person Under Investigation (PUI)
A person who has clinical criteria for EVD and has the Epidemiological risk factors

PHERC
Public Health Emergency Response Coordinator

PPE
Personal Protective Equipment

Probable Case
A PUI whose clinical criteria and epidemiologic risk factors include a high or low risk exposure

PSAP
Public safety answering point

Quarantine (Confinement)
Non-symptomatic: exposed to the disease: confined for the duration of the incubation period which is 21 days for Ebola.

COMMUNICATIONS LIST (ICS 205A)

1. Incident Name: Preventative (Pre-Ebola)	**2. Operational Period:**	Date From: 10/3/2014	Date To: Date
		Time From: HHMM	Time To: HHMM

3. Basic Local Communications Information:

Incident Assigned Position	Name (Alphabetized)	Method(s) of Contact (phone, pager, cell, etc.)
Reference WebEOC Contact List Board for ESF Contacts		http://lawebeoc.ohsep.louisiana.gov/eoc7/
State EOC Contacts		See Attachment 2
GOHSEP Regional Contacts		See Attachment 2
DHH & OPH Regional Contacts		See Attachment 2
LSP Regional Contacts		See Attachment 2

4. Prepared by: Name:		Position/Title:	Signature: ______
ICS 205A	**IAP Page**	Date/Time: Date	

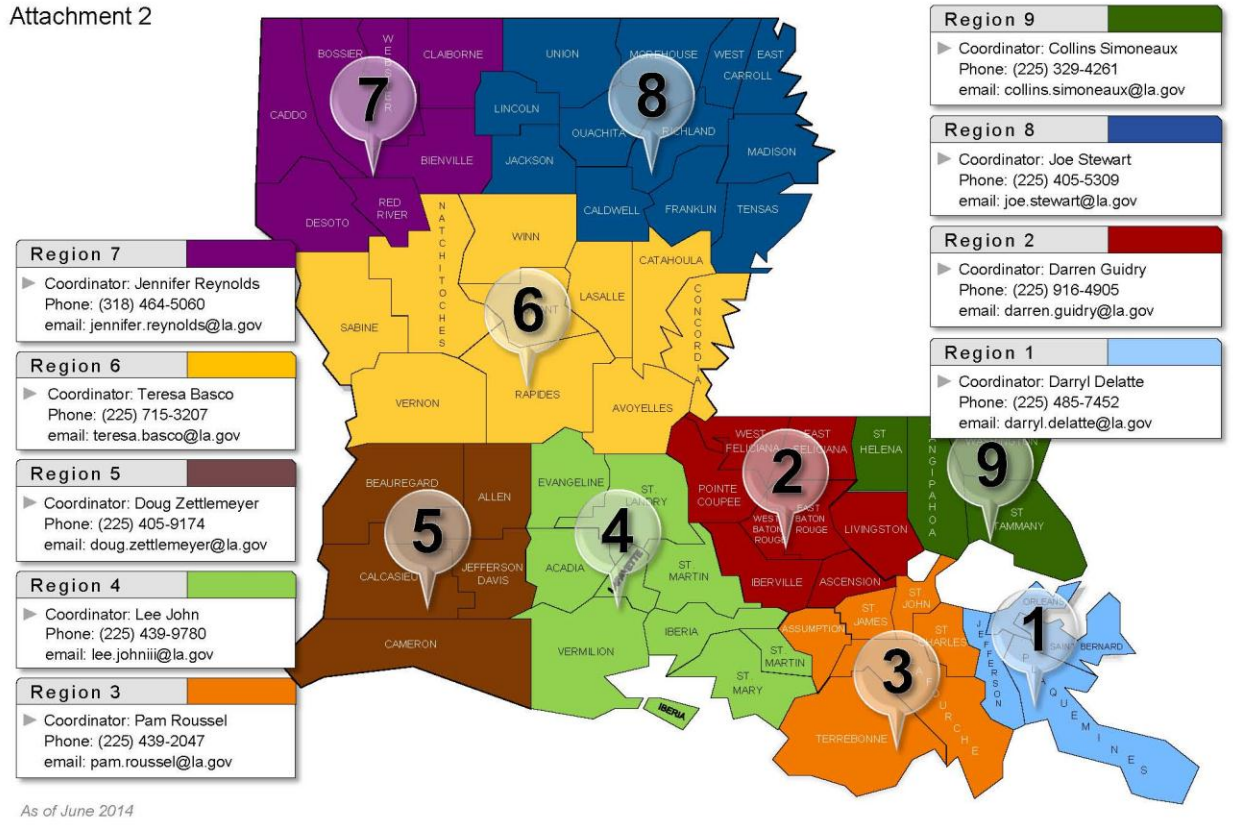
Attachment 2

GOHSEP EOC Contact Numbers

Executive Staff			
Name	Title	Office	Cell
Kevin Davis	GOHSEP Director	225-925-7345	225-252-2172
Christina Dayries	Chief of Staff	225-358-5599	225-247-0797
Executive Staff – Preparedness, Response & Interoperability (PRI) Division			
Name	Title	Office	Cell
Christopher Guilbeaux	Deputy Director	225-925-7333	225-715-3191
Kevin Breaux	Assistant Deputy Director	225-925-3506	225-573-9345
Operations Section			
Name	Title	Office	Cell
Sean Wyatt	Section Chief	225-358-5412	504-301-6166
Jason Lachney	Assistant Section Chief	225-925-7520	225-933-0173
Preparedness Section			
Name	Title	Office	Cell
David Schultz	Section Chief	225-358-5656	225-252-2005
Amy Dawson	Assistant Section Chief	225-922-2667	225-328-8642

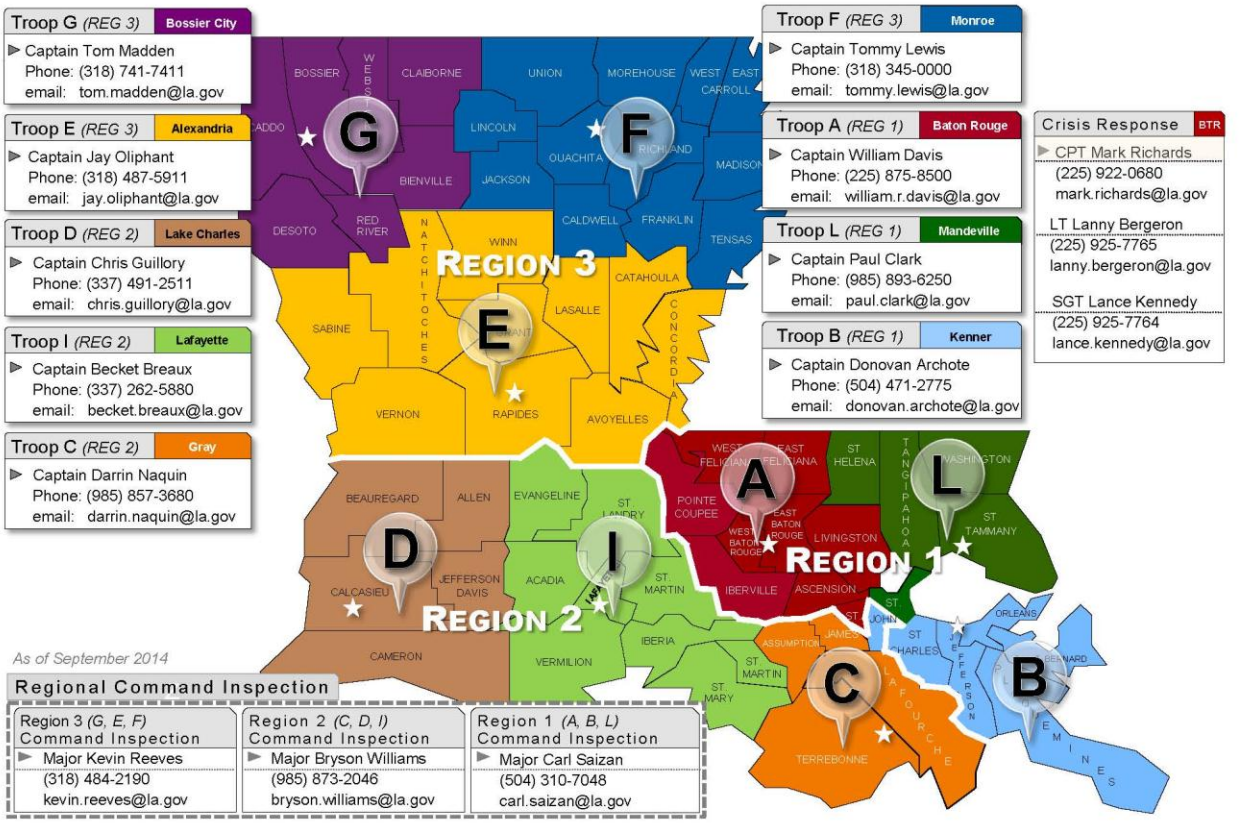
GOHSEP REGIONAL COORDINATORS

Attachment 2



As of June 2014

LOUISIANA STATE POLICE TROOPS



Ebola Information Contacts

Charlie Dupuy
225-925-6111
charlie.dupuy@la.gov

David Staton
225-925-1980
david.staton@la.gov

Taylor Moss
225-925-6113 x240
taylor.moss@la.gov

ESF8 Network

1. Parish Directors can be found at this link:
http://gohsep.la.gov/parishoepnumbers.aspx

Code:
ADM – Regional Administrator
MD – Regional Medical Director
PHERC – Public Health Emergency Response Coordinator
H-DRC – Hospital Designated Regional Coordinator
A-DRC – Administrative Hospital Designated Regional Coordinator
EMS-DRC – EMS Designated Regional Coordinator

Region 8
MD: Shelley.Jones@la.gov 225-573-6473
Assist. Admin: Jeff.Toms@la.gov 318-475-1789
PHERC: Sheila.Hutson@la.gov 318-366-5828
A-DRC: Bramem@stfran.com 318-348-7096
E-DRC: jogden238@gmail.com 318-729-2677
Daniel.Haynes@amr.net 318-801-0359

Region 7
MD: Martha.Whyte@la.gov 225-247-4988
PHERC: Frank.Robison@la.gov 225-252-3045
H-DRC: wandr1@lsuhsc.edu 318-465-9500
E-DRC: mediccraig@bellsouth.net 318-272-6593
(Craig is ONLY available for hurricane response only)
E-DRC: TBD

Region 2
MD: Marilyn.Reynaud@la.gov 225-328-8831
PHERC: Priscilla.Williams2@la.gov 225-954-2200
H-DRC: Richard.Boyer@ololrmc.com 401-338-7582
Connie.Deleo@brgeneral.org 225-572-9658
rsimp2@lsuhsc.edu 225-408-9353
E-DRC: michael.l.hammett@gmail.com 225-200-2925

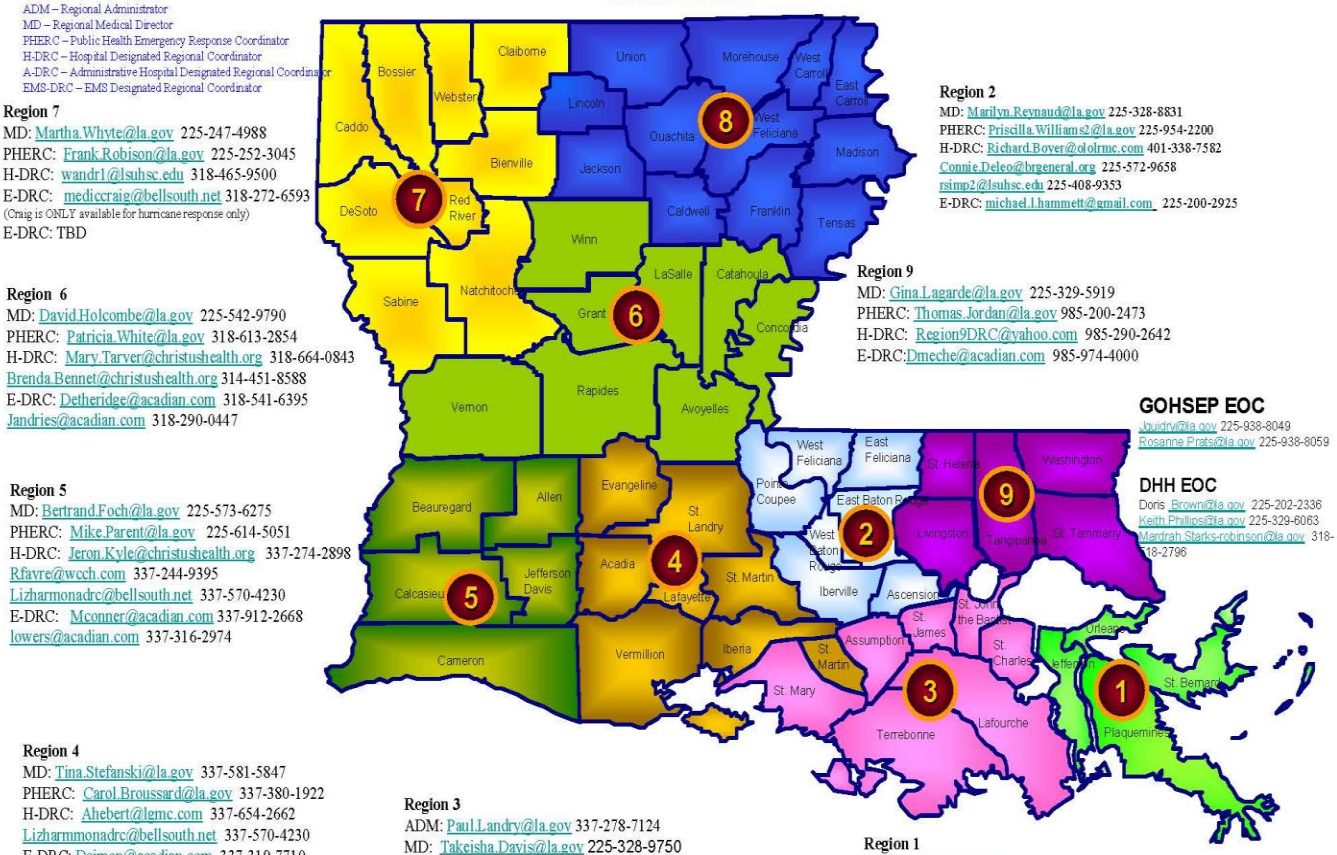
Region 9
MD: Gina.Lagarde@la.gov 225-329-5919
PHERC: Thomas.Jordan@la.gov 985-200-2473
H-DRC: Region9DRC@yahoo.com 985-290-2642
E-DRC:Dmeche@acadian.com 985-974-4000

Region 6
MD: David.Holcombe@la.gov 225-542-9790
PHERC: Patricia.White@la.gov 318-613-2854
H-DRC: Mary.Tarver@christushealth.org 318-664-0843
Brenda.Bennet@christushealth.org 314-451-8588
E-DRC: Detheridge@acadian.com 318-541-6395
Jandries@acadian.com 318-290-0447

GOHSEP EOC
Jquidry@la.gov 225-938-8049
Rosanne.Prats@la.gov 225-938-8059

DHH EOC
Doris_Brown@la.gov 225-202-2336
Keith.Phillips@la.gov 225-329-6063
Mardrah.Starks-robinson@la.gov 318-[illegible]-2796

Region 5
MD: Bertrand.Foch@la.gov 225-573-6275
PHERC: Mike.Parent@la.gov 225-614-5051
H-DRC: Jeron.Kyle@christushealth.org 337-274-2898
Rfavre@wcch.com 337-244-9395
Lizharmonadrc@bellsouth.net 337-570-4230
E-DRC: Mconner@acadian.com 337-912-2668
lowers@acadian.com 337-316-2974



Region 4
MD: Tina.Stefanski@la.gov 337-581-5847
PHERC: Carol.Broussard@la.gov 337-380-1922
H-DRC: Ahebert@lgmc.com 337-654-2662
Lizharmmonadrc@bellsouth.net 337-570-4230
E-DRC: Dsimon@acadian.com 337-319-7710
eburleigh@acadian.com 337-278-1268

Region 3
ADM: Paul.Landry@la.gov 337-278-7124
MD: Takeisha.Davis@la.gov 225-328-9750
PHERC: Kayla.Guerrero@la.gov 225-614-5053
H-DRC: Percy.Mosely@tgmc.com 985-804-5275
Region3DRC@yahoo.com 985-413-2859
E-DRC: Cdavis@acadian.com 985-637-0695
gnaquin@acadian.com 985-791-7496

Region 1
ADM: Avis.Gray@la.gov 225-328-8350
MD: Takeisha.Davis@la.gov 225-328-9750
PHERC: Sundee.Warren@la.gov 225-485-6322
H-DRC: Denice.Eshleman@touro.com 504-235-7193
A-DRC: Cindy Davidson Region1adrc@gmail.com 225-939-1313
E-DRC: Frank.Graff@careambulance-la.com 504-234-7193
At-Large/University DRC: Norris@tulane.edu 504-452-7864

Point of Contacts for ESF-8 Behavioral Health Operations Districts/Authorities

	Name	Office Phone	Cell Phone
Region 1	**Metropolitan Human Services District**	Yolanda Webb , Executive Director Charlotte Cunliffe, Deputy Director	504-535-2909 504-654-9486
Region 2	**Capital Area Human Services District**	Dr. Jan Kasofsky, Executive Director	225-266-0522
Region 3	**South Central Louisiana Human Services Authority**	Lisa Schilling, Executive Director Kristin Bonner, Deputy Director	985-688-4351 985-209-2922
Region 4	**Acadiana Area Human Services District**	Brad Farmer, Executive Director Yancey Mire, Director of BH (POC)	337-278-7671 337-303-3726
Region 5	**Imperial Calcasieu Human Services District**	Tanya McGee, Executive Director	337-802-2176
Region 6	**Central Louisiana Human Services District**	Egan Jones, Executive Director	318-730-8273
Region 7	**Northwest Louisiana Human Services District**	Doug Efferson, Executive Director Wendy Goad, Administrator	318-423-4202 318-362-4914
Region 8	**Northeast Delta Human Services Authority**	Dr. Monteic Sizer, Executive Director Mark DeBord, Regional Administrator	225-270-8324 318-381-9070
Region 9	**Florida Parishes Human Services Authority**	Melanie Watkins, Executive Director	985-974-4007
Region 10	**Jefferson Parish Human Services Authority**	Lisa English Rhoden, Executive Director	504-473-7711

Revised: June 5, 2014

List of Laboratories Approved to Perform the EUA Ebola Zaire (EZ1) rRT-PCR (TaqMan®) Assay

LRN Labs	
Arizona SPHL	Phoenix
Florida SPHL	Miami Branch
Los Angeles County PHL	Baltimore
Massachusetts SPHL	Boston
Michigan SPHL	Lansing
Minnesota SPHL	St. Paul
Montana SPHL	Helena
Nebraska SPHL	Omaha
New York City PHL	New York City
New York SPHL	Albany
North Carolina SPHL	Raleigh
Ohio SPHL	Reynoldsburg
Pennsylvania	Exton
Texas SPHL	Austin
Virginia SPHL	Richmond
Washington, DC PHL	
Washington SPHL	Shoreline

Biological Remediation Contractors

Troop A
Baton Rouge Area

Oil Mop Response, Inc.
24 Hour HOTLINE: (800) 645-6671
Locations at: Baton Rouge, Belle Chasse, Morgan City, Fourchon, Houma, Intracoastal City, Lafayette, New Iberia, New Orleans & Venice

XTreme Cleaners
P.O. Box 837
Prairieville, LA 70769
24 Hour Emergency Contact (800)524-9591
Larry Douglas (225) 276-3489
Office (225) 276-3489
Fax (225) 612-6988

B&P Enterprises
4168 Bowden
Geismar, LA 70734
Phone: (225) 474-1825 / (225)474-1825
ER Response (Nationwide) 662-781-2780

United States Environmental Services, LLC
Baton Rouge Operations
6338 Hwy 73
Geismar, LA 70734

24 Hour Phone:	(225) 673-4200 or (888) 279-9930
FAX:	(225) 677-9549
Contact:	Roy Bourgeois
	Phillip Schmidt

Contact for Biological contamination

Chip Day	(817) 845-5912
David Hamm	(601) 310-6818

Troop B
New Orleans Area

Clean Scene, LLC
514 Derbigny St.
Gretna, LA 70053
Phone: (504) 433-5777
Contact: Tommy Boudreaux
Cell: (504) 237-1960

Oil Mop Response, Inc.
131 Keating Dr.
Belle Chase, LA 70037
FAX #2 (504) 392-8977
24 Hour HOTLINE: (800) 645-6671
Locations at: Baton Rouge, Belle Chasse, Morgan City, Fourchon, Houma, Intracoastal City, Lafayette, New Iberia, New Orleans & Venice

P A Touchard Management Services
3106 Little Place
Slidell, LA 70458
Phone: (985) 643-8805
FAX (985) 646-4848
Contact: Pat Touchard
Cell (985) 640-0796
Email: patrick.touchard@bellsouth.net

United States Environmental Services, LLC
New Orleans Operations
Corporate Office
2809 E. Judge Perez Drive
Meraux, LA 70075
24 Hour Phone: (504) 279-9930 or
(888) 279-9930
FAX: (504) 279-7756
Contact: Brian Carpenter
Cell: (985)590-7089

Troop C
Houma Area

Oil Mop Response, Inc.
24 Hour HOTLINE: (800) 645-6671
Locations at: Baton Rouge, Belle Chasse, Morgan City, Fourchon, Houma, Intracoastal City, Lafayette, New Iberia, New Orleans & Venice

Troop D
Lake Charles Area

Oil Mop Response, Inc.
FAX #2 (504) 392-8977
24 Hour HOTLINE: (800) 645-6671
Locations at: Baton Rouge, Belle Chasse, Morgan City, Fourchon, Houma, Intracoastal City, Lafayette, New Iberia, New Orleans & Venice

Environmental Response Services
8583 Joe Ledoux Rd.
Lake Charles, LA 70605
P.O. Box 4288
Lake Charles, LA 70606
24-Hour No: (337) 562-0001
FAX: (337) 562-0002
Contact: Neil Clark

Miller Environmental Services
2208 Industrial Drive
Sulphur, LA 70665
Phone: (337)882-9800
(888)207-9403
24-Hr. Contact: Jeff Gully

Troop E
Alexandria Area

Advanced Specialized Carriers, LLC
4170 Pardue Rd.
Pineville, LA 71360
PO Box 3520
Pineville, LA 71361-3520
Phone: (318) 640-2098
FAX: (318) 640-2099
Advanceonsiteser@bellsouth.net
Kevin Hightower (318) 715-6158
Ray Philen (318)715-1656
Harlan Laffoon (318)729-7525

Troop G
Shreveport Area

Trauma Location Cleaner
712 Milam Street, Suite 101
Shreveport, LA 71101
Phone: (318) 227-8393
FAX (318) 227-9213
Contact: Lynn Allen

B&P Enterprises Shreveport Office
903-280-7359 Office
662-781-2780 Emergency Response (Nationwide)
Contact: Teri Sloan /Account Manager
t.sloan@bandpent.com<mailto:t.sloan@bandpent.com>
903-824-1996